### A. PATIENT DETAILS

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Consent for health assessment? *</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Consent for health assessment to be used in research?</td>
<td>Yes/No/Missing</td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Previous Health Assessment?</td>
<td>Yes/No/ Missing</td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Ethnicity: *</td>
<td>Aboriginal/Aboriginal &amp; Torres Strait Islander/Torres Strait Islander/Other/Missing</td>
</tr>
<tr>
<td>Mother’s URN: *</td>
<td>Not in ERIC/Not in ERIC</td>
</tr>
<tr>
<td>Father’s URN: *</td>
<td></td>
</tr>
</tbody>
</table>

### CLINICAL FINDINGS

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>Yes/No/ Missing</td>
</tr>
<tr>
<td>Which drug/general?</td>
<td></td>
</tr>
<tr>
<td>Metabolic and Cardiovascular Measures</td>
<td></td>
</tr>
<tr>
<td>Blood Pressure: [Systolic/Diastolic]</td>
<td></td>
</tr>
<tr>
<td>Pulse: /min</td>
<td></td>
</tr>
<tr>
<td>Weight: kg</td>
<td></td>
</tr>
<tr>
<td>Height: cm</td>
<td></td>
</tr>
<tr>
<td>BMI:</td>
<td></td>
</tr>
<tr>
<td>Waist Measurement: cm</td>
<td></td>
</tr>
<tr>
<td>Blood Glucose Level: mmol/L</td>
<td></td>
</tr>
<tr>
<td>HbA1c %</td>
<td></td>
</tr>
<tr>
<td>Urinanalysis</td>
<td></td>
</tr>
<tr>
<td>Glucose: Trace/ +/++/+++/ Missing</td>
<td></td>
</tr>
<tr>
<td>Bilirubin:</td>
<td></td>
</tr>
</tbody>
</table>
**Ketones:**
- Negative
- Trace
- +
- ++
- +++
- Missing

**Blood:**
- Negative
- Trace
- +
- ++
- +++
- Missing

**Protein:**
- Negative
- Trace
- +
- ++
- +++
- Missing

**Nitrites:**
- Negative
- Positive
- Missing

**Leucocytes:**
- Negative
- Trace
- +
- ++
- +++
- Missing

If abnormal proceed to ACR - result:
- Albuminuria: mg/L
- Creatinine:
- AC Ratio:

### Immunisation History

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
<th>Given</th>
<th>Declined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gardasil course completed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluvax due?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumovax due?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADT due?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other due?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please specify:

### Visual Acuity

**Best Vision (Use Glasses if available or pinhole):**
- With glasses
- Without glasses
- Glasses normally worn but not today
- Missing

<table>
<thead>
<tr>
<th></th>
<th>Left Eye</th>
<th>Right Eye</th>
<th>Both Eyes</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/</td>
<td></td>
<td>6/</td>
<td>6/</td>
</tr>
</tbody>
</table>

Identified Problem:

### HEALTH AND LIFESTYLE

**Smoking**

- Never Smoked:
  - Yes
  - No
  - Missing

- Ex-smoker:
  - Yes
  - No
  - Missing
  - Year that you quit: __________

- Smoker:
  - Yes
  - No
  - Missing

- Wishes to quit:
  - Yes
  - No
  - Missing

Age started:

Tobacco:
- Yes
- No
- Missing

Number of cigarettes / day:
<table>
<thead>
<tr>
<th>Pack Years:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>To complete a Fagerstrom Test, click the following</td>
<td>Fagerstrom Test</td>
</tr>
<tr>
<td>Fagerstrom Score:</td>
<td></td>
</tr>
<tr>
<td>Comment:</td>
<td></td>
</tr>
</tbody>
</table>

**Alcohol**

- Alcohol:  
  - ☐ Yes  
  - ☐ No  
  - ☐ Missing

  - If yes, please state if harmful or non-harmful levels:
    - ☐ > 2 std drinks/day avg; drinks 6-7 days/wk; > 14 std drinks/wk
    - ☐ ≤ 2 std drinks/day, 1-2 alcohol free days/wk; <14 std drinks/wk
    - ☐ > 4 std drinks on any one day
    - ☑ Missing

**Other Substances**

- Other Substances:  
  - ☐ Yes  
  - ☐ No  
  - ☐ Missing

- Opiates (heroin, methadone, codeine, endone, MS contin):  
  - ☐ Yes  
  - ☐ No  
  - ☐ Missing

- Cannabis/Yarndi:  
  - ☐ Yes  
  - ☐ No  
  - ☐ Missing

- Amphetamines (speed, base, crystal meth, ice, ecstasy, MDMA):  
  - ☐ Yes  
  - ☐ No  
  - ☐ Missing

- Cocaine:  
  - ☐ Yes  
  - ☐ No  
  - ☐ Missing

- Hallucinogen (LSD, magic mushrooms):  
  - ☐ Yes  
  - ☐ No  
  - ☐ Missing

- Volatile Substances (paints, glues):  
  - ☐ Yes  
  - ☐ No  
  - ☐ Missing

- Prescription medicine (valium, temazepam):  
  - ☐ Yes  
  - ☐ No  
  - ☐ Missing

- Over the counter medicine:  
  - ☐ Yes  
  - ☐ No  
  - ☐ Missing
### Nutrition

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you concerned about your weight?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your weight changed in the past 12 months (are your clothes tighter or looser):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has there been any change in your appetite lately?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel habits/changes including constipation:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fruit/vegetable intake in the last 24 hours:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Take-away (meals per week)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soft drink/cordial (glasses per day)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Physical Activity

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often in a week are you physically active?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you play any regular sport?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identified problems:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Hearing

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing loss:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whisper test done:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Result:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identified problems:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Actions:**

**Dental**

<table>
<thead>
<tr>
<th>Dental Problems:</th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dental Caries:</th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Gum Disease:</th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
</tr>
</thead>
</table>

**Identified Problems:**

**Mental Health**

<table>
<thead>
<tr>
<th>Mental Health Issue:</th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
</tr>
</thead>
</table>

Select applicable:

**Depression:**

- Yes
- No
- Missing

*If yes, please do K10*

**Suicidal ideas:**

- Yes
- No
- Missing

*If yes, please do K10*

**Anxiety:**

- Yes
- No
- Missing

*If yes, please do K10*

**Psychosis:**

- Yes
- No
- Missing

**Bipolar:**

- Yes
- No
- Missing

**Illicit drugs:**

- Yes
- No
- Missing

**Family problems:**

- Yes
- No
- Missing

**Relationship problems:**

- Yes
- No
- Missing

**Grief:**

- Yes
- No
- Missing

**Stress:**

- Yes
- No
- Missing

**Identified Problems:**

To complete an Outcome Tool (K10), click the following

**Outcome Tool (K10)**

**Outcome Tool (K10) score:**

**Skin**

<table>
<thead>
<tr>
<th>Skin:</th>
<th>Any skin problems</th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Lesion to check</th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Rash unspecified</th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Scabies</th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Pus</th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition</td>
<td>Yes</td>
<td>No</td>
<td>Missing</td>
</tr>
<tr>
<td>------------------</td>
<td>-----</td>
<td>----</td>
<td>---------</td>
</tr>
<tr>
<td>Psoriasis</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Skin cancer</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Fungal</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Eczema/Allergies</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Identified Problems:**

**WOMEN'S HEALTH**

**Urinary Problems:**

- ☐ Yes
- ☐ No
- ☐ Missing

**Identified Problems:**

**Pap smear due:**

- ☐ Yes
- ☐ No
- ☐ Missing
- ☐ Given
- ☐ Declined

**Last done:**

**Mammogram due:**

- ☐ Yes
- ☐ No
- ☐ Missing

**Last done:**

**Contraception required:**

- ☐ Yes
- ☐ No
- ☐ Missing

- Condoms
- OCP
- Mini Pill
- Depo
- Implanon
- Mirena
- Other
- IUD
- Other
- Missing

**Comment:**

**Sexual Health Check**

**Any problems?**

- ☐ Yes
- ☐ No
- ☐ Missing

**Symptoms or concerns?**

**Chlamydia and Gonorrhea screening advised:**

- ☐ Yes
- ☐ No
- ☐ Missing

**Hepatitis B, HIV, Syphilis screening advised:**

- ☐ Yes
- ☐ No
- ☐ Missing

**Have you had any unsafe sex in the last year?**

- ☐ Yes
- ☐ No
- ☐ Missing

**Hepatitis C Risks**

**Exposure to Hepatitis C**

- ☐ Yes
- ☐ No
- ☐ Missing
<table>
<thead>
<tr>
<th><strong>Tattoos</strong></th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IVDU</strong></td>
<td>Yes</td>
<td>No</td>
<td>Missing</td>
</tr>
<tr>
<td><strong>Incarceration history</strong></td>
<td>Yes</td>
<td>No</td>
<td>Missing</td>
</tr>
<tr>
<td><strong>Investigation and Advice undertaken</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Client’s Overall Health Status**
- Very Good
- Good
- Fair
- Poor
- Very Poor
- Missing

**Current health problems:**

**Current medications (include OTC medication and medication from other doctors)**

**Community and Family**
- **Family Medical History**

**Family Issues:**
- | Yes | No | Missing |
  - Adult | Child | Missing |

**Number of children:**

**Ages of children:**

**Are you cared for by someone else?**
- Yes | No | Missing

**Environmental and Living Conditions**
- **Identified problems:**
  - Homelessness | Yes | No | Missing
  - Overcrowding | Yes | No | Missing
  - Conflict at home | Yes | No | Missing
  - Other | Yes | No | Missing

**Please specify:**

**Employment Status:**
- **Employed full-time** | Yes | No | Missing
- **Employed part-time** | Yes | No | Missing
- **Voluntary work** | Yes | No | Missing
- **Unemployed** | Yes | No | Missing
- **Study full-time** | Yes | No | Missing
| Study part-time | □ Yes  □ No  @Missing |
| Carer          | □ Yes  □ No  @Missing |
| Home duties    | □ Yes  □ No  @Missing |
| Disability pension | □ Yes  □ No  @Missing |
| Other pension  | □ Yes  □ No  @Missing |
| Casual         | □ Yes  □ No  @Missing |
| Contract Work  | □ Yes  □ No  @Missing |

**Medical History/Examination by GP**

New diagnosis from this health check:  □ Yes  □ No  @Missing

If Yes, please specify:

**Accidents and Injuries**

Have you had any accidents (including motor vehicle) that have required hospital or GP review since last health check?  □ Yes  □ No  @Missing

If Yes, please specify:

**Medication Review**

Medication Review:  □ Yes  □ No  @Missing

Medication Compliance:

- Takes most doses
- Takes some doses
- Does not take meds
- @Missing

Identified Problems:

**Cholesterol**

Cholesterol / Trig:  _______ / _______

HDL / LDL:  _______ / _______

Total Cholesterol / HDL:  _______

**Known Health Problems**

- Asthma
- Hypertension
- Cerebrovascular Disease
- Ischemic Heart Disease
- Chronic Kidney Disease
- Rheumatic Heart Disease
- COPD
- Type 2 Diabetes
- Dyslipidemia
### PROBLEM LIST

### ACTIONS

- **Advice:**
  - [ ] Yes
  - [ ] No
  - [ ] Missing

- **Comments:**
  - [ ]

- **Pap Smears:**
  - [ ] Yes
  - [ ] No
  - [ ] Missing

- **Comments:**
  - [ ]

- **New Medications:**
  - [ ] Yes
  - [ ] No
  - [ ] Missing

- **Comments:**
  - [ ]

- **Immunisation:**
  - [ ] Yes
  - [ ] No
  - [ ] Missing

- **Comments:**
  - [ ]

- **Referrals:**
  - [ ] Yes
  - [ ] No
  - [ ] Missing

  - **Referral to Optometrist:**
    - [ ] Yes
    - [ ] No
    - [ ] Missing

  - **Referral to Ophthalmologist:**
    - [ ] Yes
    - [ ] No
    - [ ] Missing

  - **Referral to physiotherapists / exercise group:**
    - [ ] Yes
    - [ ] No
    - [ ] Missing

  - **Referral to Mental Health Service:**
    - [ ] Yes
    - [ ] No
    - [ ] Missing

  - **Referral to Audiologist/Australian Hearing:**
    - [ ] Yes
    - [ ] No
    - [ ] Missing

  - **Referral to dietician:**
    - [ ] Yes
    - [ ] No
    - [ ] Missing

- **Comments:**
  - [ ]

- **Other Action:**
  - [ ] Yes
  - [ ] No
  - [ ] Missing

- **Comments:**
  - [ ]
Health Check Completed by:

Signed:

Date: